No. 93-120

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY
d/b/a Thomas Jefferson University Hospital,
Petitioner,

v.

DONNA E. SHALALA, SECRETARY
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS FOR
THE THIRD CIRCUIT

JOINT APPENDIX

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Petition for Certiorari filed July 20, 1993
Certiorari granted January 10, 1994

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INDEX

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

I. U.S. DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Louis W. Sullivan, M.D., Secretary of Health and Human Services, No. 90-CV-2036, Judge William H. Yohn, Jr., filed March 23, 1990.

DATE	DESCRIPTION
3/23/90	Complaint.
6/6/90	Answer of Defendant.
12/12/90	Motion by Plaintiff Thomas Jefferson For Leave To File Amended and Supplemental Complaint, Memorandum in Support (Complaint attached).
1/9/91	Order that Plaintiff shall have leave to file an amended and supplemental Complaint within 10 Days, etc.
1/14/91	Answer to amended and supplemental Complaint by Defendant Louis Sullivan [Entry date 1/15/91].
4/19/91	Praecipe by Defendant Louis Sullivan to file attached administrative transcript [Entry date 4/22/91].
8/16/91	Motion by Defendant Louis Sullivan for Summary Judgment, Memorandum in Support.
8/19/91	Motion by Plaintiff Thomas Jefferson for Summary Judgment, Memorandum in Support.

DATE	DESCRIPTION
9/18/91	Reply by Defendant Louis Sullivan to Plaintiff's Cross-Motion for Summary Judgment [Entry date 9/19/91].
9/18/91	Response by Plaintiff Thomas Jefferson in Opposition to Defendant's Motion for Summary Judgment [Entry date 9/19/91].
4/27/92	Stipulation and Order that the Secretary will instruct the fiscal intermediary, AETNA, to calculate amounts due, and pay those amounts to Thomas Jefferson within 90 days, etc. Plaintiff agrees to a dismissal of its cause of action seeking reimbursement for the costs, etc. Nothing in this agreement shall preclude Plaintiff from bringing an action before the Court for breach of this agreement or to enforce the terms of this agreement, etc. [Entry date 4/28/92].
5/1/92	Memorandum and Order that Plaintiff shall submit within 10 days an affidavit setting forth the date upon which the Final Decision of the Secretary denying reimbursement of certain costs claimed by the Hospital for Fiscal Year 1985 was received; Plaintiff's Motion for Summary Judgment is denied; Defendant's Motion for Summary Judgment is granted; Judgment is entered for Defendant and this case shall be marked as Closed. (Signed by Judge William H. Yohn Jr. on 5/4/92) [Entry date 5/4/92].

DATE	DESCRIPTION
6/22/92	Notice of Appeal by Plaintiff Thomas Jefferson Copies to Judge William H. Yohn Jr., Clerk USCA, Appeals Clerk, and David F. McComb, Michael M. Baylson, Linda A. Ruiz, Dona S. Kahn, Joel Tornari [Entry date 6/23/92] [Edit date 6/23/92].
6/22/92	Copy of Clerk's Notice to USCA re Appeal [Entry date 6/23/92].
7/21/92	Transcript for Oral Argument Before Judge William H. Yohn, Jr. on 4/10/92 [Entry date 7/22/92].
7/22/92	RECORD COMPLETE FOR PURPOSES OF APPEAL.

II. U.S. COURT OF APPEALS FOR THE THIRD CIRCUIT

Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Louis W. Sullivan, M.D., Secretary of Health and Human Services, No. 92-1513

DATE	DESCRIPTION
6/24/92	Civil Case docketed. Notice filed by Thomas Jefferson.
7/23/92	Certified List filed.
9/1/92	Brief of Appellant Thomas Jefferson.
9/1/92	Appendix of Appellant Thomas Jefferson.
10/13/92	Brief of Appellee Secretary HHS.
10/16/92	Motion filed by Appellee to file supplemental Appendix.

DATE	DESCRIPTION
10/22/92	Order (Clerk) granting motion to file supplemental Appendix by Appellee with filing as of the date of this Order.
10/22/92	Appendix of Appellee Secretary HHS.
10/29/92	Reply Brief of Appellant Thomas Jefferson.
10/29/92	Supplemental Appendix of Appellant Thomas Jefferson.
11/20/92	Motion of Appellee to file response to new material in Appellant's Reply Brief.
11/20/92	Response by Appellee to new material in Appellant's Reply Brief.
4/21/93	Judgment-Order (Mansmann, Authoring Judge, and Alito and Aldisert, Circuit Judges) Affirmed. Costs taxed against Appellant.
7/30/93	U.S. Supreme Court Notice filed advising Petition for Writ of Certiorari filed by Appellant Thomas Jefferson. Filed in the Supreme Court on 7/20/93, Supreme Court case number: 93-120.
1/14/94	U.S. Supreme Court Order, dated 1/10/94, granting Petition for Writ of Certiorari by Appellant Thomas Jefferson.
1/31/94	Letter dated 1/26/94 from U.S. Supreme Court Clerk requesting that we certify and transmit the entire record to their Court.
2/2/94	Certified copy of briefs, appendices and partial proceedings in this Court sent to U.S. Supreme Court Clerk.

TESTIMONY OF MARK L. RICHARDS

TESTIMONY OF ARTHUR G. BOLL

June 19, 1989
Before the Provider Reimbursement Review Board

Thomas Jefferson University Hospital

v.

AETNA Life Insurance Company
Case No. 86-1588

Appearances:

McDermott, Will & Emery, Chicago, Illinois,
By: James M. Gaynor, Jr. and Mary Zerega,
for Thomas Jefferson University Hospital

AETNA, By: Paul R. Gulbrandson, for AETNA.

MARK L. RICHARDS, having been called as a witness on behalf of Thomas Jefferson University Hospital, being first duly sworn, testified on his oath as follows:

DIRECT EXAMINATION

BY MS. ZEREGA:

[142][1] Q. Did you do any further re-evaluation of your costs claiming — 1985?

[1] For the convenience of the Court, we have provided a citation to the A.R. page rather than the court reporter's transcript page.

[143] A. Yes we did. At the insistence of the dean and the medical school in terms of their unwillingness to continue to support graduate medical education in the hospital we engaged the firm of Touche, Ross to evaluate what costs were actually being incurred by the hospital — or correction by the medical school on behalf of the hospital for graduate medical education.

Also, the clerical costs claimed in 1984 were not the — as well documented as we would have liked and this study would also in fact clarify and solidify the costs that were being claimed for clerical costs.

Q. Were the results of that cost study used as the basis for the Provider's 1985 reimbursement — ?

A. Yes they were. The cost study — we agreed to get the cost study in February of 1985. The fiscal year closed June 30th, 1985 and the actual meat of the study did not begin until the summer of 1985 since it would be required that the books of the medical school and the hospital be closed after the fiscal year for them to begin serious work on this undertaking.

Q. So the cost study — was the cost study completed at the time that the cost report was submitted in 1985?

A. No it was not. The actually [sic] cost study performed by Touche, Ross was still under way at the [144] time of the cost report filing and as a result the Provider booked an A-8 adjustment to the cost report to reflect additional costs which might be documented by Touche, Ross.

Q. What was different about the costs claimed in '85?

A. The costs claimed in 1985 aside from the typical costs claimed by the hospital which included salaries, fringe benefits of the faculty and clerical costs included some other items which had not been previously claimed but were documented by the Touche, Ross study. These costs included non-salary costs incurred by the medical school, depreciation and space costs of the medical school related to graduate medical education and also overhead costs incurred by the medical school related to graduate medical education. All documented by the Touche, Ross study.

* * * *

CROSS EXAMINATION

BY MR. GULBRANDSON:

[192] A. Which exhibit is that please?

Q. I-13. Would you look at page 3 of that letter.

A. Yes.

Q. Would you tell me what the intent of that little chart that there's all those numbers of there is?

A. The numbers as a whole reflect those costs that could be supported by the hospital as graduate medical education costs.

Q. Are these increase costs that the hospital will be claiming?

A. That is correct.

Q. And therefore the share born [sic] by the medical school will be decreased?

A. In some case, yes.

Q. I don't suppose you'd call that a redistribution?

A. No I would not.

Q. When were these costs identified?

A. Well I'm not exactly sure when they were identified but I believe it was probably an estimate by Mr. Boll at some point during the summer and based upon initial assessments.

* * * *

EXAMINATION BY THE PRRB

MR. OWENS:

[205] The intermediary believes that a redistribution occurred. You believe it does not. Could you tell us why you believe it does not?

A. I believe that the cost over the years for graduate medical education have increased significantly and that the hospital has not kept up the pace of the increasing costs of graduate medical education. If the hospital funded to the medical school back in 1973, one million dollars I think it would be extremely unrealistic to expect the same amount of money, one million dollars, to be funded in 1985. Obviously, there is a growth of expenditures here and in fact the hospital has had

a huge growth in the residency programs as well as in the number of full-time faculty. As a result of this growth and this [206] full-time faculty and in the number of residents associated with the hospital there has been portionate [sic] increases in graduate medical education costs and it's something that we believe that the hospital should be paying for. So there has been a substantial growth in graduate medical education costs over the years and also the fact that the medical school is getting more and more squeezed since these costs are now being borne by the medical school.

* * * *

MR. OWENS:

[207] Were those elements components that you'd also recognized in previous years? I want to make [208] sure I understand.

A. Yes they were and again the pure professorial salary run which includes the physician's activity reports and nothing additional. No clerical costs, no overhead or anything else.

MR. OWENS:

Now the Touche Ross study dwells more upon new components that you hadn't utilized before?

A. Yes. The Touche Ross study examined other areas which the Dean believed, he was incurring significant costs for, mainly in the area of non-salary costs.

MR. OWENS:

Space,

A. Yeah space, overhead and so forth. In addition, clerical costs were also fully documented in the '85 year.

MR. OWENS:

Now once again the bottom line on '86 was accepted in full by the intermediary?

A. Yes.

MR. OWENS:

With any question?

A. That is correct.

MR. OWENS:

And one last question. The Touche Ross injection of components that had previously been unrecognized in your cost report, that is not regarded by the provider as redistribution either is that correct?

A. No it is not and it reflects the growth over time, substantial costs incurred by the medical school which at one point back in '73, '74 or '75 may have been [209] inconsequential and not of serious consideration for our consideration to be funded by the hospital.

* * * *

MR. BRAGONZA:

In 1984 which entity bore the non-salary costs, the space costs and the complete clerical costs?

A. The medical school. Now the hospital bore the professorial salary costs and clerical costs.

MR. BRAGONZA:

I'm talking about the non-salary costs and the space costs?

A. The medical school.

MR. BRAGONZA:

In 1984 the medical school bore those costs?

A. That's correct.

MR. BRAGONZA:

In 1985, you're claiming then it was the hospital.

A. Yes that's correct.

MR. BRAGONZA:

Isn't that a redistribution of costs?

A. No. I believe it's a growth of costs that should be recognized by the hospital that incurred by the medical [210] school over time and at one point were inconsequential.

MR. BRAGONZA:

In 1984 were they inconsequential?

A. No. That's why the Dean was screaming at the hospital to support these costs.

MR. BRAGONZA:

They weren't inconsequential in 1984?

A. No they were not.

MR. BRAGONZA:

Who bore them in '84?

A. Medical school.

MR. BRAGONZA:

So there was at least a transfer if not a redistribution, call it what you will, in 1984 the medical school bore some costs that were not inconsequential and in 1985 the hospital is bearing them, claiming them?

A. That is correct.

MR. BRAGONZA:

In your opinion that's not a redistribution?

A. No it's not.

* * * *

CHAIRWOMAN SMITH:

[215] So what you're saying is that you believe that Medicare should bear some of the burden of those costs because those costs are incurred in running the program that actually takes place at the hospital?

A. That is correct and in fact those secretaries could just as easily be assigned to a hospital payroll

number or part of the salary could be assigned to a hospital payroll if necessary and they could be paid directly by the hospital but we've always used this transfer mechanism in the past and had no objection from the intermediary in terms of funding these types of activities.

CHAIRWOMAN SMITH:

So what you did through the Touche Ross study was simply, well not simply, you reached out and pulled in further categories of costs or just increased costs, categories from which it had always been allowed before?

A. No. I would say that in terms of the clerical support we provided additional documentation because we had claimed that in 1984, but we did expand upon the categories of those costs claimed that we had never claimed [216] before and those included the non-salary costs, overhead, space and so forth, but the salaries and fringe benefits of the physicians and clerical costs had been claimed in the past.

CHAIRWOMAN SMITH:

I see. So the focus of the Touche Ross study was to arrive at some kind of method for breaking those out of the medical schools costs is that correct?

A. Yes it was and in order to document the amount of costs associated with graduate medical education I believe it was necessary for Touche Ross to segregate all the costs into their component parts and develop appropriate methodologies to be used to segregate those costs and develop appropriate allocations that would be acceptable basis for charging those costs to the hospital.

* * * *

ARTHUR G. BOLLS, having been called as a witness on behalf of Thomas Jefferson University Hospital, being first duly sworn, testified on his oath as follows:

DIRECT EXAMINATION

BY MR. GAYNOR:

[229] Q. And subsequent to the Thomas Jefferson [230] engagement have you done studies for other teaching institutions?

A. Yes I have. I think five other university teaching hospitals.

Q. Do you have an opinion as to whether teaching hospitals as a group have been re-evaluating their practices with respect to claiming medical school costs?

A. I have a very strong opinion. They clearly are. The reason that I think that I've been involved in studies like this is that the issue of what are the costs of graduate medical education that are benefitting the hospital or performed in the hospital environment and the level of reimbursement by the hospital to the medical schools for those services is becoming a major issues, as the hospitals, as the medical schools are coming under

increasing financial pressures. If you look at the traditional financing sources of graduate medical education they have been in the areas of essentially state appropriations, practice plan revenues, and to the extent that the hospital has paid cash reflected through charges to the payors. Those have been traditionally the three. Further complicating it is the reality that the Gramm-Rudman and other deficit reduction acts have put increasing pressures on states to reduce their support for graduate medical education. There's been a redesign and [231] greater limitations on the A21 indirect cost methodology under the federal grants. There's been changes in strategies as to how to award federal grants. All of which have continued to create financing pressures. Then you go into the whole area of Medicare as hospitals now and particularly a hospital like Thomas Jefferson has significant dependence on the practice plan contributions in order to finance the cost of graduate medical education. Those practice plans of physicians in their private practice are coming under greater financial pressures because of reimbursement reform and competition in the marketplace. So that the traditional source of the financing in the School of Medicine which incurred and paid the vast bulk of the cost of graduate medical education are now starting to go away or be undermined. The issue now becomes what is the appropriate and the most [s]table long-term financing structure for graduate medical education and if you ask the Deans, their opinion is to get those costs properly reflected on the books of the hospital

and passed them on to in terms of charges to create some stability in the financing structure.

* * * *

[236] Q. I believe your testimony was that in a number of these institutions the driving force behind re-evaluation of cost claims was the medical school?

A. That's correct.

Q. And not the hospital?

A. The hospital is a willing participant. I mean they're both related parties. They both face off to the future together. I'm not sure there can be a viable university teaching hospital without a viable medical school. They're so linked because the teaching hospitals provide the capital and facilities base and what I'll call the patient care support. The medical schools provide the programmatic initiatives in terms of physicians with leading in surgical or diagnostic capability that [237] essentially operate in the university hospital setting.

* * * *

[239] Q. Did 413.85 as it applied to Thomas Jefferson fiscal year '85, require offset of restrictive gifts?

A. No it did not because when the PPS regulations were implemented that requirement for the offset of restricted grants was taken away.

Q. So that the only offset that the regulation addresses is tuition? We've heard some discussion this morning about the question of redistribution and the language found in 413.85 sub-paragraph c. I assume you've given some consideration to that language in preparing your cost studies?

A. Yes I have. Given a lot of consideration and a lot of research.

Q. And what have you found in terms of, have you found any explications of that language in other areas of Medicare program policy, general instructions for instance?

A. Well certainly when you, if you look at the written material, the issue of redistribution was not something that was really articulated and to the best of my knowledge not applied prior to early 1985. It may have been but it certainly hasn't come under my attention prior to that. It has since then been you know discussed and I think from the regulations its not very well defined [240] exactly how it is applied. I think if we look back to the prior [PRRB] rulings and look for some applications I think it gives a general framework but specifics, the one case where it's given a specific example is where a hospital rents classroom space in support of a program occurring in the hospital and that was determined in the program manual to be okay

and not a redistribution. I mean that's about the only specific reference that it's given.

Q. So you're not aware of any discussion of redistribution principle in general instructions as such?

A. No. Subsequent there's been intermediary letters, guidance or whatever that have essentially started to define from their viewpoint what redistribution is.

* * * *

STATEMENT BY MR. GAYNOR:

[242] . . . We have produced in our exhibits a series of exchanges of correspondence between the Health Care Financing Administration, regional office, and the University of Oregon with respect to that institutions attempts to claim reimbursement for medical school costs that had not previously been claimed. This letter which the intermediary has introduced and I believe is in our exhibits as well is a kind of general discussion of the allowability of such cost claims and our only point is that as late as March 7, 1986, there is no reference to the notion of redistribution applying to a type of activity at Oregon that we are engaged in here with respect to Thomas Jefferson.

CHAIRWOMAN SMITH:

That was the point also of your including the other exchanges and the letters in your documents?

MR. GAYNOR:

Correct. Because there is no published discussion we have been able to find that we were able to obtain through discovery of the redistribution concept. The best we could do was try to find examples of situations in which HCFA approved in some fashion the kind of cost claim that Thomas Jefferson is seeking. Indirect evidence of what the agency's own view was, is of redistribution and that is,

CHAIRWOMAN SMITH:

All right. Thank you.

* * * *

[328] A. My position would be, my position is that I think Leonard gave the best example I've ever seen that says the cost was never that cost. It was a cash amount derived from historical negotiations and we need to establish what the cost is and the cost or the payment from the hospitals never kept track with the increased cost of the medical school and so we were underpaying for services that we were provided.

MR. BRAGONZA:

Through the change in methodology is resulting in costs being borne by the program that were previously borne by the school.

A. Yeah it had to be.

MR. BRAGONZA:

Had to be.

A. By definition had to be.

MR. BRAGONZA:

At least we can agree on that. They were previously borne by the school. They're not being borne by the program.

A. Well they're previously borne by the entity but yeah, okay. . . .

* * * *

MR. BRAGONZA:

[330] And that's why I have not quite the macro view that you have Mr. Boll and that's, I'm trying to struggle with it. I recognize the point you're making in that the long-term there may be a problem but I'm still trying to reconcile the facts and circumstances of this hospital with this regulation.

A. I'll still go back to my utilities case.

MR. BRAGONZA:

Thank you. I have no further questions.

CHAIRWOMAN SMITH:

I just want to understand the payment issue a little bit better. If the provider were to prevail and get reimbursement that it asked for for 19, fiscal year 1985, would that go over to the medical school?

A. I would, yeah, I mean that's my understanding.

CHAIRWOMAN SMITH:

Turn around and pay the medical school?

A. Those are the costs. Just, one of my clients, one of my university hospital medical school clients, not TJU. They're looking at programmatic and capital investment needs of 40 million dollars over the next three years. So I mean the money will be, and a lot of them say we need to make, we need to create a source for these [331] activities.

EXHIBITS FROM ADMINISTRATIVE RECORD

Excerpts of Department of Health and Human Services Memorandum from Albert J. Benz, Associate Regional Administrator in Division of Financial Operations, to Director of Office of Reimbursement Policy, dated March 29, 1982

Date: March 29, 1982

From: Associate Regional Administrator
Division of Financial Operations

Subject: Allowability of Costs Incurred by a Teaching Hospital for Services Rendered by Faculty at a Related Medical School.

To: Director, Office of Reimbursement Policy

Attached is a report, "Reimbursement for Costs Relating to Teaching Physicians—Issue Analysis," which was prepared by the Executive Consulting Group, Inc. for the University Hospital of the University of Oregon Health Sciences University. The report concludes that supervision and training is provided by University of Oregon Medical School physicians to medical students, interns, and residents in the University Hospital and that the associated costs are reimbursable under the Medicare and Medicaid programs. These costs are identified at $2.6 million. Also suggested by the report is an effort analysis methodology for the identification of these "allowable" training and supervision costs.

The report was provided to us by the hospital's intermediary, Oregon Blue Cross, who has asked for our review and determination of the allowability of the costs and the suggested methodology.

Because of the significance and potential national implication of this issue and the absence of specific guidelines in this area, we request your review of this report and policy clarification regarding the allowability of these costs. We require policy guidance in three areas: allowable activities, acceptable methodologies, and other concerns.

Allowable Activities

Chapter 400 of the Provider Reimbursement Manual contains the cost principles pertaining to the costs of educational activities; however, it does not specifically address the costs of medical school faculty providing services to a hospital. Only in Section 406 is the relationship between a medical school and a teaching hospital addressed. This section implies a prohibition against transferring medical school costs to a hospital.

> "it is not intended that this program should pay for increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units."

However, Intermediary Letter (IL) 78-7 contains policy allowing certain costs of educational institutions.

> ". . . reasonable costs incurred by a teaching hospital for patient care services rendered by the faculty of the medical school in the hospital are allowable hospital costs provided such costs would be allowable if incurred directly by the hospital rather than under such arrangement."

Unfortunately, IL 78-7 did not further define allowable faculty services. Therefore, at this point, we have concluded that certain faculty activities with regards to teaching hospitals are allowable, but we are unable to clearly define those activities. Please provide clarification of allowable faculty activities. To which patient care services does IL 78-7 refer? Are supervision and training of residents, interns, and medical students as claimed

by University Hospital allowable patient care services per IL 78-7?

* * *

Other Concerns

1. Reasonableness - As indicated, University Hospital has identified approximately $2.6 million of costs associated with training and supervision of residents, interns and medical students. Identification procedures are not precise and allowable activities apparently are not clearly defined, therefore, we see a potential that additional costs may be claimed. Can you provide us with any information upon which we and the intermediary may make a determination of the reasonableness of these costs?
2. Medical School Indirect Costs - Per IL 78-7, we have concluded that reimbursement of medical school indirect costs calculated via the medical school indirect cost rate are not allowable for transfer to the hospital along with the allowable medical school faculty costs. Is this correct?
3. Physician Compensation - Once an allowable activity has been identified, how should it be costed? What consideration should there be of the physicians' Part B reimbursement?

Please contact Robert Reed of my staff at FTS 399-1382 [if] further clarification is required.

[Signed by Albert J. Benz]

Excerpts of Health Care Financing Administration Memorandum from Bernard J. Patashnik, Director of Division of Institutional Services, to Albert J. Benz, Regional Administrator, dated May 4, 1982

May 4, 1982

Refer to: FQA-531

Division of Institutional Services
Reimbursement, Reimbursement Policy, BPP, HCFA

Allowability of Costs Incurred by a Teaching Hospital for Services Rendered by Faculty at a Related Medical School (Your Memo Dated 3/26/82)-INFORMATION

Regional Administrator
Seattle
Attention: Albert J. Benz

You requested that we review a consultant report regarding allocation of medical school costs that was prepared for the University of Oregon. You also asked for clarification of policies pertaining to three specific issues. Our comments are grouped according to those issues.

1. Allowable Activities

The allocation of costs to a hospital from a related medical school is governed by Intermediary Letter 78-7. The costs of services can be allocated to the hospital only when the services would have been allowable if the hospital had incurred the costs directly. Thus, the services must be related to the care of hospital patients and cannot be duplicative of services already available in the hospital.

The allowable provider component of physicians' services includes: supervision of residents, interns and medical students providing or assisting in providing services to hospital patients, and rounds and patient care conferences

relating to hospital patients. Non-allowable services includes: teaching formal courses, grading papers, and assisting in medical school curriculum development.

* * *

3. Other Concerns

Medical school costs being allocated to a hospital should be assessed in the same manner as any other hospital cost. The cost should be assessed in terms of the amount of services the hospital received and compared to similar costs incurred by other hospitals. As you surmised, the medical school cannot transfer indirect costs calculated via an indirect cost rate to the hospital.

We do not understand your question about how allowable activities should be costed". Total physician compensation is allocated to the various allowable and unallowable activities using an allocation methodology as discussed in item 2 above. Thus, it is merely necessary to know what portion of time is spent in the various activities. Once the costs associated with the various activities are determined in accordance with IL 78-7, the individual amounts would be included in the appropriate cost centers. Reimbursement for physicians' professional services is handled just as it would be in any other hospital-based physician situation in a teaching setting.

Bernard J. Patashnik
Director

Health and Human Services Memorandum From Linda M. Magno, Director of Division of Hospital Payment Policy, to Associate Regional Administrator of Division of Financial Operations, dated December 29, 1985

December 29, 1985

Refer To: FQA-56

Director
Division of Hospital Payment Policy, BERC

Oregon Health Sciences University—Allowability of Salary Costs of University Medical School Teaching Faculty (Your Memorandum Dated October 25, 1985)—INFORMATION

Associate Regional Administrator
Division of Financial Operations
Seattle Regional Office

This is in response to your request for clarification of our policy concerning education costs incurred by the medical school but allocated to the university hospital.

In your memorandum to us, you mentioned that a May 4, 1982, memorandum from central office stated that Intermediary Letter 78-7 governed the allocation of costs to a hospital from a related medical school. However, the central office memorandum did not specifically discuss the policy with respect to the redistribution of costs from a medical school to a hospital. The fact that this issue is not mentioned in the subject memorandum does not change the basic policy as espoused in 42 CFR 405.421(c). This section of the regulations provides that where costs for items and services were previously borne by a medical school, their allocation to a university hospital represents a redistribution of costs from an educational institution to a patient care institution. In such situations, these costs are not reimbursable under the Medicare program.

In general, educational activities conducted by a medical school related to a hospital, while enhancing the ability of interns and residents to provide quality health care services, are not directly related to the care of specific patients for whom a teaching hospital is responsible. For this reason, such activities do not meet the requirements set forth in 42 CFR 405.451. On the other hand, certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, *may* represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents, and the conducting of rounds and patient care conferences relating to hospital patients. More specifically, services that are both related to the care and treatment of the hospital's patients and furnished in support of the clinical training of interns and residents meet the requirements for reimbursement.

Such items and services must be necessary and *directly* related to the rendition of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, those costs may be allowable that are incurred by the university medical school which can be directly related to the training program for the interns and residents working in the university hospital.

In conclusion, allowable costs that were previously borne by the medical school and allocated to the hospital represent a redistribution of costs from an educational institution to a patient care institution. Accordingly, such costs would not be reimbursable under the Medicare program. In view of this and the fact that such redistributed costs were allowed by the intermediary in settled cost reports for FYE June 30, 1982 and FYE June 30, 1983, the cost reports for these two reporting periods should be reopened and the redistributed costs disallowed.

If you have further questions regarding this matter, please contact Jack Jones of my staff at FTS 987-2884.

Linda M. Magno

Excerpts of Letter from Linda M. Magno, Director of HHS Division of Hospital Payment Policy, to David M. Witter, Jr., Interim Hospital Director at The Oregon Health Sciences University, dated March 7, 1986

Mr. David M. Witter, Jr.
Interim Hospital Director
The Oregon Health Sciences University
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97201

Dear Mr. Witter:

This is in further response to your inquiry regarding Medicare reimbursement for certain teaching physician costs incurred by the Oregon Health Sciences University hospital and Medical school. You are concerned about the allowability under Medicare of certain medical school faculty costs not previously claimed by the hospital for reimbursement purposes.

In general, educational activities conducted by a medical school related to a hospital, while enhancing the ability of interns and residents to provide quality health care services, are not directly related to the care of specific patients for whom a teaching hospital is responsible. For this reason, such activities do not meet the requirements set forth in regulations at 42 CFR 405.451. On the other hand, certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, *may*

represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents in activities for which no Part B charge is rendered, and the conducting of rounds and patient care conferences relating to hospital patients. More specifically, services that are both related to the care and treatment of the hospital's patients and furnished in support of the clinical training of interns and residents meet the requirements for reimbursement.

Such items and services must be necessary and *directly* related to the rendition of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs may be allowable that are incurred by the university medical school and are directly related to the training program for the interns and residents working in the university hospital.

* * *

Sincerely yours,

[signed]

Linda M. Magno
Director, Division of Hospital
Payment Policy

LEGISLATIVE HISTORY OF MEDICARE ACT

— HEARINGS ON H.R. 1

Excerpts of: Medical Care for the Aged: Hearings on H.R. 1 and Other Proposals Before the House Committee on Ways and Means, 89th Cong., 1st Sess. 223, 247 (Feb. 2, 1965)

Mr. ULLMAN. One of the problems, and we came to this when we were analyzing the method of cost indexing of these hospitals, is the fact that most hospitals are charging off a lot of their extras in the ordinary hospital bill. Isn't it true that in every hospital bill there is a great deal of cost involved covering more or less extraneous factors such as training programs for nurses that might be financed some other way?

Have you thought of any alternative?

Dr. CROSBY. On the principles of payment which we advocate the third party bear we recommend that they pay a reasonable amount for education within these hospitals. This is not only education of nurses, but it is education of interns, and residents, and the other paramedical field, technicians of one sort or another, physical therapists and so forth.

H.R. REPORT NO. 213

Excerpt of: Social Security Amendments of 1965, Report on H.R. 6675, 89th Cong., 1st Sess. 32 (March 29, 1965)

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance

the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

SENATE REPORT NO. 404
Excerpt of: Social Security Amendments of 1965, S. Rep. No. 404, 89th Cong., 1st Sess. 36 (June 30, 1965)

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

EXCERPT OF AMERICAN HOSPITAL ASSOCIATION'S PRINCIPLES OF PAYMENT FOR HOSPITAL CARE

2.302

In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community.

COMMENT . . . Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursement cost of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time that such cost can be transferred to other sources.

EXCERPTS OF REGULATORY HISTORY OF 42 C.F.R. § 413.85

20 C.F.R. § 405.421 (1966)

31 Fed. Reg. 14808, 14814 (Nov. 22, 1966): Department of Health, Education and Welfare, Title 20 - Employees' Benefits, Chapter III — Social Security Administration, Part 405 - Federal Health Insurance of the Aged, Principles for Reimbursable Costs

§ 405.421 Cost of educational activities.

(a) *Principle.* An appropriate part of the net cost of approved educational activities is an allowable cost.

(b) *Definitions*—(1) *Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(2) *Net cost.* The net cost means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations.

(3) *Appropriate part.* Appropriate part means the net cost of the activity apportioned in accordance with the methods set forth in these principles.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the

community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *"Orientation" and "on-the-job training".* The costs of "orientation" and "on-the-job training" are not within the scope of this principle but are recognized as normal operating costs in accordance with principles relating thereto.

(e) *Approved programs.* In addition to approved medical, osteopathic, and dental internships and residency programs, recognized professional and paramedical educational and training programs now being conducted by provider institutions, and their approving bodies, include the following:

	Program	Approving bodies
(1)	Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology of the American Society of Clinical Pathologists.
(2)	Dietetic internships . . .	The American Dietetic Association.

(3) Hospital administration residencies	Members of the Association of University Programs in Hospital Administration.
(4) Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(6) Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse anesthetists	The American Association of Nurse Anesthetists.
(8) Professional nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.

(9) Practical nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(10) Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy residencies	American Society of Hospital Pharmacists.
(12) Physical therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(13) X-ray technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and the Social Security Administration to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the health insurance program.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 405.421(g)(1), 45 FED. REG. 51783, 51786-87 (AUG. 5, 1980)

Excerpts:

45 Fed. Reg. at 51783 —

SUMMARY: This final rule amends the regulation governing Medicare payments to providers of services for their costs of approved educational activities. Under the current regulation, providers are required to deduct all grants designated for specific education programs from their costs of those programs in calculating their costs that are reimbursed by Medicare. Under the amended regulation, providers will not be required to deduct grants for primary care internship and residency programs. The rule is intended to avoid nullifying the purposes of specific grants for these programs.

* * *

Background

Under Medicare, a provider of services (a hospital, skilled nursing facility or home health agency) is reimbursed on the basis of the costs it incurs in furnishing services to Medicare beneficiaries. Current Medicare regulations specify that, in determining the costs reimbursed under Medicare, the provider may include its net costs of educational activities approved in accordance with the regulations at 42 CFR 405.421. Net cost is currently determined by deducting all grants, tuition, and specific donations from the provider's incurred costs for the educational activity (42 CFR 405.421(b)(2)). However, we have found that these deductions undermine the purpose of grant programs designed to support primary care internship and residency programs. Specifically, the deduction of a grant reduces the provider's costs recognized for Medicare reimbursement, thereby preventing the provider from realizing the full benefit of the grant. We believe this thwarts one of the purposes of title VII of the Public Health Service Act, which is to foster the

development of programs designed to train physicians in primary care specialties. Therefore, we have changed the regulation to specify that deductions will not be made for grants and donations received to support these programs. Instead, if hospital revenues for these programs exceed cost, HCFA will notify grant donors so they may make adjustments if called for.

* * *

42 Fed. Reg. at 51786-51787 —

42 CFR 405.421 is amended by revising paragraph (a), redesignating paragraph (b)(1) as paragraph (b), deleting paragraphs (d)(2) and (b)(3), and adding new paragraphs (g) and (h) to read as follows:

§ 405.421 Cost of educational activities.

* * *

(g) *Calculating net cost.* (1) Except as specified in paragraph (g)(2) of this section, net costs of approved educational activities are determined by deducting from a provider's total costs of these activities, revenues it receives from tuition, and from grants and donations that the donor has designated for the activities. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 405.421(g), 49 FED. REG. 234, 296 (JAN. 3, 1984)

Excerpt:

Comment—One commenter questioned whether paragraphs (g) and (h) of § 405.421, which deal with the treatment of grants and donations, should be removed as the result of the deletion of § 405.423 (Grants, gifts, and income from endowments) in the interim final rule.

Response—We agree that a revision is necessary. We have therefore revised § 405.421 by revising paragraph (g)(1) and removing paragraphs (g)(2) and (h). This change merely makes the regulations consistent with the change that was made in the interim final.

Grants, gifts and income from endowments—Section 405.423 was eliminated effective for cost reporting periods beginning on or after October 1, 1983. As a result, restricted grants and gifts will no longer be used to offset costs. We received several comments commending us for making this change in policy.

42 C.F.R. § 413.85 (1985)

§ 413.85 Cost of educational activities.

(a) Payment — (1) General rule. Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to apportionment based on Medicare utilization as described in § 413.50.

(b) Definition — Approved educational activities. Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) Educational activities. Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the

community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

* * * *

(g) Calculating net cost. Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 413.85, 54 FED. REG. 40286, 40288, 40301, 40302 (SEPT. 29, 1989)

Excerpts:

54 Fed. Reg. at 40288 —

1. Determining Base-Period per Resident Amounts

   a. Methodology

* * *

In establishing the base-period per resident amount for a specific hospital based on FY 1984 GME costs, it is important that the amount determined be an accurate reflection of legitimate GME costs incurred during the FY 1984 base period. Because the payment methodology required by section 1886(h) of the Act sets future payments using the FY 1984 base-period amounts as the initial starting point, we believe that it is very important that inappropriate costs not be included in the base-period amount. Therefore, we proposed to instruct Medicare contractors to reexamine FY 1984 GME costs and to request appropriate supporting documentation in those cases in which reported costs seem questionable.

54 Fed. Reg. at 40301 —

Comment: One commenter suggested that, during any reaudit activity, hospitals should be able to introduce additional GME costs not previously claimed, as well as misclassified costs, to augment base-period GME costs.

Response: We would seriously question the legitimacy of costs introduced 4 or 5 years after the base-period cost report was prepared by the hospital. However, if it can be demonstrated to the satisfaction of the fiscal intermediary that legitimate GME costs were inadvertently omitted from the base-period cost report, then these costs could be introduced during the reaudit activity. However, these costs would have to

be supported by actual documentation developed during the GME base period that was maintained in a format that can be audited. Costs other than GME costs could not be introduced if the cost report is not otherwise subject to being reopened.

54 Fed. Reg. at 40302 —

Comment: Some commenters expressed concern about treatment of GME costs of a related medical school. One commenter pointed out that, in some complexes, GME activities may take place in space assigned to the medical school, and that it would be unfair to impose a restriction on the location of allowable GME patient care activities in large academic health care centers for reimbursement purposes. Another commenter was concerned that medical schools often are adequately funded by grants from State and local governments, so it seems inappropriate for the medical school under such circumstances to also pass-through such costs to the hospital. In the opinion of the commenter, we should address whether there is a redistribution of GME costs when State appropriations or other funding sources are sufficient to cover the costs of operating the medical school.

Response: We agree that determination of allowable costs of related medical schools can be a complicated matter. We are guided by the general principle that, to be allowable at all, the costs must be related to patient care furnished in the hospital, and, to be allowable as a direct GME cost, the costs must be related to the GME program in the hospital. Certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents in activities for which no Part B charge is made and the conducting of rounds and patient care conferences related to hospital patients. To reiterate, services that are both related to the care and treatment of the hospital's patients and furnished in

support of the training of interns and residents meet the requirements for payment.

These items and services must be necessary and directly related to the provision of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs that are incurred by the university medical school may be allowable if it can be demonstrated to the satisfaction of the fiscal intermediary that such costs are directly related to the training program of the interns and residents working in the university hospital and are related to the care and treatment of the hospital's patients.

In the past, hospitals have alleged that the related organization principle set forth in § 413.17 requires Medicare to reimburse a hospital for a share of all costs of a medical complex or even of the entire university on the basis that the component entities were indistinguishable from the whole. Our policy concerning related organizations was established to avoid program recognition of costs of a provider for services furnished by a related organization in excess of the costs incurred by the related organization, and to avoid payment of artificially inflated costs that might be generated from less than arm's length bargaining. This policy was not intended to expand the range of items and services for which a provider could claim Medicare reimbursement, or to include items and services not specifically related to patient care.

With respect to the comment that we should address the issue of funding that covers the costs of operating the medical school, our policy prior to October 1, 1983 provided that restricted grants (those grants that were designated by the donor for paying certain specified provider costs) were deducted from the designated costs incurred by the provider. Unrestricted

contributions, however, would not be deducted from such costs. Section 901 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499) added section 1134 of the Act. This provision affirmed the Secretary's authority not to offset donor-restricted grants and gifts that the Secretary finds, in the best interests of needed health care, should be encouraged. The policy that restricted grants could be offset against allowable costs incurred by providers was changed effective October 1, 1983 (as provided in the September 1, 1983 final rule (48 FR 39797)). Thereafter, any grant monies received by a provider could not be offset against the reimbursable amounts due the provider under Medicare.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 413.85, 57 FED. REG. 43659 (SEPT. 22, 1992)

* * *

Excerpts:

57 Fed. Reg. at 43660 —

SUMMARY: This proposed rule would set forth in regulations our policy on Medicare payment for the costs of approved nursing and allied health education programs, an action directed by section 6205(b)(2) of the Omnibus Budget Reconciliation Act of 1989. In addition, it would implement the provisions of sections 4004(b)(1) and (2) and 4159(b)(1) and (2) of the Omnibus Budget Reconciliation Act of 1990. In general, except for the changes required by the latter statute, the provisions set forth in this proposed rule restate or clarify our current policies governing these costs, which have been previously set forth in the Provider Reimbursement Manual and other documents but have not been included in the regulations. We also are proposing to amend the list of approved nursing and allied health education programs and to clarify the payment method-

ology for certified registered nurse anesthetist education programs.

I. Background

Medicare has historically paid providers for its share of the costs they incur in connection with approved educational activities. The activities may be broken down into the following three general categories to which different payment policies apply:

- Approved graduate medical education (GME) programs in medicine, osteopathy, dentistry, and podiatry. Current policy on Medicare payment for GME costs is found at 42 CFR 413.86, which was added by a final rule published in the Federal Register on September 29, 1989 (54 FR 40286). In general, for each hospital cost reporting period beginning on or after July 1, 1985, GME costs are paid on the basis of a hospital-specific per resident amount multiplied by the hospital's weighted number of full-time equivalent (FTE) residents for that cost reporting period.
- Approved nursing and allied health (paramedical) education programs operated by the provider. The costs of these programs are excluded from the definition of inpatient operating costs and are not included in the calculation of payment rates under the prospective payment system or in the calculation of the target amount subject to the rate of increase ceiling for hospitals and hospital units excluded from the prospective payment system. These costs are separately identified and "passed through" (that is, paid on a reasonable cost basis).
- Other educational programs and activities.

All other costs that can be categorized as educational programs and activities are considered to be part of normal operating costs and have been covered by the per case payments made under the inpatient hospital prospective payment system for hospitals subject to that system or on the basis of reasonable

cost subject to the rate-of-increase limits for hospitals and hospital units excluded from that system.

This proposed rule discusses the history of Medicare and the costs associated with approved nursing and allied health education programs and sets forth our proposed policy on payment for these costs.

A. The Social Security Amendments of 1965 (Pub. L. 89-97)

The subject of Medicare payment for a provider's costs of educational activities arose during the committee hearings prior to the establishment of the Medicare program with the enactment of Public Law 89-97. In January and February 1965, a representative from the American Hospital Association (AHA) testified before the House Committee on Ways and Means. The representative testified that the AHA advocated that third parties pay a reasonable amount for education within the hospitals, not only for nurses but also for interns, residents, technicians, and the other allied health fields (H.R. Rep. No. 213, 89th Cong., 1st Sess. 33 (1965)). At the same hearing, the Commissioner of the Social Security Administration testified that, on the matter of educational costs, the principles of the AHA would be followed.

Thus, in complying with the reports of the committee, the drafters of the regulations implementing title XVIII of the Act were guided by the "Principles of Payment for Hospital Care" first published by the AHA in 1953, with slight modification in 1961 and 1963. The AHA's Reimbursement Principle No. 2.302 stated that, "In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community." The publication went on to comment that —

> Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursable cost of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time that such cost can be transferred to other sources.

57 Fed. Reg. at 43661 —

Title XVIII of the Act created a 16-member body to provide advice in the formulation of Medicare regulations. This group, the Health Insurance Benefits Advisory Council, met in December 1965 and included the costs of educational activities in its discussion of Medicare reimbursable costs. The minutes of this meeting show that the Council considered the following principle: "A part of the net cost of educational activities shall be included as an element of reimbursable cost." The Council accepted the principle, subject to the inclusion of the word "approved" before the words "educational activities." It asked the staff to study further the problem of differentiating between

teaching related to patient care and teaching unrelated to patient care. In January 1966, when the Council met again, comment was made that the resolutions comprise only a basic statement of policy and that the Administration would have to refine the policies to adapt them to various situations, formulate and publish regulations, and establish guidelines and procedures, both to implement the policy recommended by the Council and to prevent abuses. This position was consistent with the definition of "reasonable cost" in the original section 1861(v)(1)(A) of the Act, which authorizes the Secretary to define "reasonable costs" in various circumstances by issuing implementing regulations. The Council confirmed by formal voting procedures that "the net cost of approved educational activities should be included as an element of reimbursable cost."

There was no statutory requirement in Public Law 89-97 nor in any subsequent amendment to title XVIII of the Act specifying the types of nursing and allied health education programs for which Medicare should pay its share of the costs. However, both the House and Senate Committee reports accompanying Public Law 89-97 indicate that Congress favored including a part of educational expenses as allowable costs:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

(S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965)).

(In this document, we have substituted the term "allied health" for "paramedical," since Medicare currently allows the costs of approved training programs for medical records librarians, medical technologists, and other disciplines for which the term "allied health" is more appropriate, and this is the term most commonly used to refer to this category of health care professions.)

B. Net Cost of Approved Educational Activities

The regulation that evolved from this legislation, 20 CFR 405.421 (redesignated as 42 CFR 405.421 on September 30, 1977 and as 42 CFR 413.85 on September 30, 1986), was first published in the Federal Register on November 22, 1966 (31 FR 14814). In the original regulation (20 CFR 405.421(b)(2)), net cost was defined as "the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations." The regulations also defined approved educational activities as "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution." (20 CFR 405.421(b)(1).)

The types of costs that were allowable as costs of approved educational activities early in the Medicare program were set forth in both the applicable regulation and in Chapter 4 of the Provider Reimbursement Manual (HCFA-Pub. 15-1). The original regulation specifically excluded "orientation" and "on-the-job training" from the definition of approved educational activities (20 CFR 405.421(d)). Further, as early as 1971, Chapter 4 of the Provider Reimbursement Manual stated that "any costs of usual patient care" are also excluded from that definition (§ 404.2). The Provider Reimbursement Manual specified that the costs of usual patient care were allowable, but only as normal

operating costs and not as educational costs. On the other hand, during this time, the Provider Reimbursement Manual did include within the scope of allowable educational activities, under certain conditions, such other educational expenses as costs associated with refresher and postgraduate programs, part-time education for bona fide employees of the provider, travel expenses for educational workshops, and training in the use of medical appliances for patients or their care-givers.

Both the regulation and the Provider Reimbursement Manual repeated the congressional committee report language from 1965 that Medicare would share in the costs of educational activities until communities bore them in some other way. Neither of these sources, however, included any criteria to use in determining whether responsibility for a program had been assumed by a community. Nonetheless, it was clearly stated in both the regulation and the Provider Reimbursement Manual that it was not intended that Medicare should pay for increased costs resulting from a redistribution of costs from educational institutions to providers (20 CFR 405.421(c) and § 404.2 of the Provider Reimbursement Manual).

* * *

57 Fed. Reg at 43662 —

H. The January 1983 Provider Reimbursement Manual Revision

* * *

Section 404.2 of the Provider Reimbursement Manual, as revised in January 1983, specified that provider costs incurred for clinical training associated with an approved program operated by an entity other than a provider could be allowable. Further, it specified that costs incurred by a provider that were associated with the classroom portion of the program could be allowable if the following three criteria were met:

- The provider's support does not constitute a redistribution of nonprovider costs to the provider. The support must be in addition to the costs already being incurred by the nonprovider-operated program. If the nonprovider entity reduced its costs due to receiving provider support, this reduction constitutes a redistribution of costs from an educational institution to a patient care institution and is a nonallowable provider cost.
- The provider receives a benefit for the support it furnishes.

57 Fed. Reg. at 43663 —

- The cost of the provider's support is less than the cost the provider would incur were it to operate the program.

These criteria adopted in January 1983 addressed the allowability of costs incurred by a provider in support of a nonprovider-operated educational program. Since the revision to Chapter 4 of the Provider Reimbursement Manual predated the Medicare prospective payment system for inpatient hospital services, it did not address the issue of whether such costs were to be considered part of normal operating costs or treated as a "pass-through cost."

* * *

57 Fed. Reg at 43665 —

II. Proposed Revisions

* * *

57 Fed. Reg. at 43668 —

D. Definition of Net Costs

We are proposing to revise the current definition of net costs. The definition currently states "net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition."

When the regulations were revised, it was assumed that the tuition paid by students enrolled in approved educational programs was intended to cover all facilities and services for which a provider would incur costs. It was not our intention to imply that costs for which a provider charges a separate fee, in addition to tuition, were not to be considered as part of the cost of the approved educational activity. Two examples of such costs are the purchase of textbooks for resale to students and the provision of housing or room and board in exchange for an additional fee. We are proposing to clarify in the regulations that the term "tuition" was intended to include these additional charges and fees.

We also are clarifying the definition of net costs in the proposed regulations to indicate that "total costs" was intended to include only direct and indirect costs incurred by a provider that are directly attributable to the operation of an approved educational activity. Such costs do not include usual patient care costs that would be incurred in the absence of the educational activity, such as the salary costs for nursing supervisors who oversee the floor nurses and student nurses. Moreover, we believe that such costs do not include costs incurred by a related organization. The current regulation concerning related organizations at § 413.17 was established to avoid program recognition of artificially inflated costs that might be generated from less than arm's length bargaining. This policy was not intended to expand the range of items and services for which a provider could claim payment. With respect to educational costs (with the limited exception for certain graduate medical education costs incurred by a related medical school as provided in Intermediary Letter 78-7), our policy has been that the provider, rather than the related organization, must directly incur the costs on its books and records before the costs will be recognized for Medicare payment purposes. Otherwise, the principle that Medicare payment for medical education costs should not result

in a redistribution of costs from the educational institution to the provider would be violated.

* * *

In the final rule of January 3, 1984 (49 FR 234), the definition of net costs in paragraph (g) of § 405.421 (now § 413.85(g)) was revised by eliminating grants and donations from revenues that were to be offset against the cost of approved educational activities. This revision was made in response to a public comment to ensure that the policy on net cost of educational activity would be consistent with the policy that deals with the treatment of grants, gifts, and income from endowments under reasonable cost payment under § 413.5(c)(3). However, we are reconsidering our position on this issue. As a result, we are requesting public comment on whether the net costs of approved educational activities should be defined as the costs determined by deducting the revenues that a provider receives from tuition, student fees, and the allocable amounts from any donations, grants, and non-Medicare public funding from the provider's total allowable costs that are directly related to approved educational activities.

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57 Fed. Reg. at 43671 —

We are proposing to amend 42 C.F.R. part 413, subpart F as set forth below:

* * *

2. Section 413.85 is revised as follows:

§ 413.85 Cost of approved educational activities.

(a) *General payment rule*. Except as provided in paragraph (b) of this section, payment for a provider's net cost of approved educational programs is determined on a reasonable cost basis.

(b) *Payment on other than a reasonable cost basis*. (1) *Graduate medical education programs*. For cost reporting periods beginning on or after July 1, 1985, payment to hospitals and

hospital-based providers for approved residency programs in medicine, osteopathy, dentistry, and podiatry is determined as provided in § 413.86.

* * *

57 Fed. Reg. at 43672 —

(c) *Definitions*. (1) *Net costs*. Net costs of approved educational activities means the costs determined by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable costs that are directly related to approved educational activities. For this purpose, a provider's total allowable costs include costs incurred by the provider for trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24. Except as provided in paragraph (f) of this section, total allowable educational costs do not include usual patient care costs, costs incurred by a related organization, or costs that constitute a redistribution of costs from an educational institution to a provider. Net cost is subject to apportionment for Medicare utilization as described in § 413.50.

(2) *Redistribution of costs*. Redistribution of costs is defined as an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education that were incurred by an educational institution rather than the provider in its prospective payment or rate-of-increase limit base year cost report are not allowable costs in subsequent fiscal years.

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PROVIDER REIMBURSEMENT MANUAL, PART 1, § 404.2

Costs of Approved Nursing and Paramedical Education Programs

The responsibility for operating and supporting approved educational programs which are necessary to meet the community's needs for nursing and paramedical personnel should be borne by the community. Where the community has not yet recognized and accepted this responsibility, the Medicare program does participate appropriately in the support of such approved programs as are operated by providers in conjunction with their patient care activities. However, it is not intended that Medicare should be responsible for expenditures by a provider in subsidizing such programs that are operated by other organizations where the provider receives no, or disproportionately little, benefit for the amount it expends.

Accordingly, a provider's reasonable costs associated with approved nursing and paramedical education programs are allowable as follows:

A. Provider-Operated Programs. — Costs incurred in these programs including costs of classroom training and costs of clinical training are allowable.

B. Non-provider-Operated Programs Supported by Providers. — The manner in which provider support whether in cash or in kind is furnished may vary depending on the circumstances. The classroom portion of these programs is often, but not always, conducted in a non-provider setting. The clinical training portion generally is conducted in a provider or other health care setting. Costs incurred for the clinical training at the provider are allowable. Costs incurred which are related to the classroom portion are allowable if the following three criteria are met.

1. The provider's support does not constitute a redistribution of non-provider costs to the provider.

   The support must be in addition to the costs already being incurred by the non-provider operated program. If the non-provider reduces its costs due to receiving provider support, such reduction constitutes a redistribution of cost from an education institution to a patient care institution and as such is not an allowable provider cost. Reg. 405.421(c).

2. The provider is receiving a benefit for the support it furnishes.

3. The provider's support is less than the cost the provider would be expected to incur with a program of its own.

Examples of Provider Support. —

1. A provider begins support of a new, or an expansion of an existing, non-provider program for the purpose of assuring an adequate supply of trained staff not otherwise available in the area. Criterion No. 1 is met because the support is for costs not previously borne by the non-provider. Criterion No. 2 is met because the provider is receiving a benefit, i.e., assurance of availability of trained staff, for the support it furnishes. For criterion No. 2 to continue to be met, the provider must be able to document on an ongoing basis that it continues to receive a supply of trained staff. Criterion No. 3 will be met if the provider can document that it will incur less cost under this arrangement than it would incur with a program of [its] own.

2. A provider agrees to support a non-provider program already supported by other providers in order to assure itself an adequate supply of trained staff not otherwise available in the area. There is no increase in the total amount of support being made by all of the participating providers except for increases reasonably related to inflation. Criterion No. 1 is met because the provider is not bearing costs previously borne by the non-

provider but rather costs that were borne by the other providers. Criterion No. 2 is met so long as the provider can document that it continues to receive the benefit of a supply of trained staff for the support it furnishes. Criterion No. 3 will be met if the provider can document that it will incur less cost under this arrangement [than] it would incur with a program of its own.

C. Clinical Training Conducted in a Provider Setting Where Classroom Training Costs Are Not Allowable. — Costs of clinical training are allowable provided the training is conducted in conjunction with an approved program and relates to the care of provider patients.